# MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-003
Revised5/16

| Reporting Hospital | Abstracted By | Date Abstracted | Date Received by MCTR |
|---|---|---|---|
| | | | |

## PATIENT INFORMATION

Facility # Accession # Sequence # Date First Contact Medical Record Number

Name of Patient Last First Middle Maiden Alias | Primary Payer

Physical Address No & Street City County State Zip Code

| Social Security Number | Date of Birth | Facility Referred From | Facility Referred To |
|---|---|---|---|
| | | | |

| Race | Hispanic Origin | Sex | Age | Marital Status | Name of Spouse/Parent | Place of Birth |
|---|---|---|---|---|---|---|
| | | | | | | |

| Telephone Number | | Tobacco History | Alcohol History |
|---|---|---|---|
| | | | |

| Usual Occupation | Usual Industry |
|---|---|
| | |

Follow-Up Contact - Name (not spouse) Relationship No & Street City State Zip Code Telephone Number

## CANCER INFORMATION

| Date of Diagnosis | Primary Site | Laterality | Other Primary Tumors |
|---|---|---|---|
| | | | |

**Place of Diagnosis** (if diagnosed elsewhere, please describe place)

☐ This Hospital ☐ Other Hospital
☐ Physician's Office ☐ Unknown ☐ Other _____

**Diagnostic Confirmation**

☐ Histology ☐ Cytology ☐ Microscopic ☐ Lab Test
☐ Visual ☐ X-ray ☐ Clinical ☐ Unknown

**Diagnostic Summary** (document details of physical evaluation, pathology, scopes, x-rays/scans, and lab tests including date and name of procedure(s), slide #, facility, specimen, histology, grade, behavior, tumor size, extension, surgical margins, LN's involved and examined). **Attach copies of surgical or pathology reports and discharge summaries, if necessary.**

**Collaborative Staging**

Tumor Size _____ Describe Size _____
Extension _____
Regional Lymph Nodes *Positive* _____ Regional Lymph Nodes *Examined* _____
Sites of Distant Metastases _____
Substantiate Stage _____

**SEER Summary Staging**

☐ In-situ ☐ Local ☐ Regional ☐ Distant ☐ Unknown

**AJCC Staging**

☐ Clinical ☐ Pathological

T _____ N _____ M _____ Stage Group _____

## TREATMENT INFORMATION

**Cumulative Treatment Summary** (document details of biopsy, surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason)

## OUTCOMES

**Status**

Date of Last Contact or Death _____
Vital Status ☐ Alive ☐ Dead
Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown
Cause of Death _____
Autopsy ☐ Yes ☐ No ☐ Unknown
Place of Death _____

**Recurrence**

Recurrence Date _____
Recurrence Type
☐ In-situ ☐ Local ☐ Regional
☐ Distant ☐ Unknown
Describe _____

**Comorbidities and Complications** (ICD-10-CM)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Physician – Surgeon Physician – Follow-Up Physician - Managing Physician – 3 Physician – 4

**Fax to Montana Central Tumor Registry, (406) 444-6557.**
**This form can be found on http://dphhs.mt.gov/publichealth/Cancer/TumorRegistry**